



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ADVANCED NEUROMODULATION SYSTEMS
6901 PRESTON ROAD
PLANO TX 75024

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

LIBERTY MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-07-0807-01

MFDR Date Received

OCTOBER 5, 1006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In accordance with Medicare Guidelines we have billed the IPG Accessory Kit Battery Charger as procedure code E1399, in the amount of \$1350. Sincere there is no specific code for this item we must use the code E1399 which is the standard HCPCS code for 'durable medical equipment, miscellaneous;. We are consistently reimbursed at 100% of the billed charge for procedure code E1399. Even CMS Medicare determined items billed as procedure code E1399 to be fully allowable. Procedure code E0752 is described as 'Implantable neurostimulator electrode, each; and is defined by HCPCS to be bill per each electrode... Furthermore, we have billed our Spinal Cord Stimulator Equipment per the Guidelines established by CMS. The 'E' codes we submitted are classified as 'durable medical equipment'. CMS, Not ANS, regulates and establishes these procedure codes. HCPCS and the Texas Fee Guidelines substantiate this classification. The TDI-DWC Medical Fee Guideline 134.202(c),(2) specifically states: (c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (2) for Healthcare Common Procedure Coding System (HCPCS Level II Codes A, E, J, K, and L: (A) 125% of the fee listed for the coded in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; With this factor in place we can expect \$1350 (fully allowed by Medicare) for procedure code E1399 and \$7449.80 for procedure code E0752 (that's 5959.84 x 125%)... Therefore, we are requesting additional payment from Liberty Mutual I the amount of \$3,263.80 in accordance with the Texas Fee Guidelines as noted above."

Amount in Dispute: \$5,263.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have received the medical dispute filed by Advanced Neuromodulation Systems for services rendered to [injured employee] on date of service 10/17/05. The bill and documentation attached to the medical dispute have been re-reviewed and our position remains the same. Our rational is as follows: ...The provider is the actual manufacturer of the product... No evidence or invoices to support their actual were submitted with the initial bill or three subsequent appeals... The provider is requesting reimbursement at 125% of the fee listed for the code in Medicare DME POS F/S... Per the provider's letter, the procedure performed was a surgically implanted rechargeable internal pulse generator spinal cord stimulator. The EON rechargeable IPG Spinal Cord stimulator is a full implantable device, which offers the capability to be recharged by the patient... Since this is an implant device it was paid as such, rather than being paid as a piece of durable medical equipment. Liberty Mutual paid per the Texas Fee Schedule rules at cost plus 10% per in-house comparison invoices rather than as a piece of durable medical equipment at 125% of the fee listed for the

code in Medicare DME POS F/S. It is believed that the provided has been reimbursed fairly and reasonable for these items. No documentation has been submitted to support that the provider's actual cost exceeded this amount we paid. Liberty Mutual does not believe that Advanced Neuromodulation Systems Inc. is due any further reimbursement for services rendered to [injured employee] on date of service 10/17/2005."

Response Submitted by: Liberty Mutual Insurance, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 17, 2005	HCPCS Codes E0752 and E1399	\$5,263.80	\$4,677.76

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out reimbursement guidelines.
3. 28 Texas Administrative Code §134.1 sets out guidelines for fair and reasonable reimbursement.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 16, 2006 and January 24, 2006:

- W1 (Z560) – The charge for this procedure exceeds the fee schedule or usual and customary allowance.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Findings

1. The insurance carrier position was that "since this is an implantable device it was paid as such, rather than being paid as a piece of durable medical equipment. Liberty Mutual paid per the Texas Fee Schedule rules at cost plus 10% per in-house comparison invoices rather than as a piece of durable medical equipment at 125% of the fee listed for the code in Medicare DME POS F/S." In accordance with 28 Texas Administrative Code §134.202(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (2)for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A)125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. According to the 2005 Expert HCPCS Level II code book HCPCS Code E0752 is defined as "Implantable neurostimulator electrode, each." The DMEPOS fee schedule amount is \$372.49 per electrode. The requestor billed for 16 electrodes, using HCPCS Level II Code E0752. The fee guideline amount is Medicare's pricing of \$372.49 times 125% equals \$465.61 per electrode; for a grand total of \$7,449.76. Liberty Mutual paid \$2,772.00. Therefore, additional reimbursement is due.
2. Per 28 Texas Administrative Code §134.202(c)(6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments. In accordance with 134.1(c)Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission. In accordance with 28 Texas Administrative Code 133.307(g)(3)(D) if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title and §134.1 of this title. The requestor states in their position summary that "We are consistently reimbursed at 100% of the billed charge for procedure code E1399." The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$4,677.76.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$4,677.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	November 9, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.